Commonwealth Coordinated Care
Medicare & Medicaid working together for you

The Beneficiary Experience – January 2017

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IN BRIEF

As part of their review of the CCC Program, evaluation staff observed 191 hours of care coordination activities and interviewed 81 beneficiaries (including family members), 55 care coordinators, and 41 providers. This document, which focuses on the experiences of one beneficiary, family member, provider, and his two care coordinators, is the fifth (and final) in a series of short case studies that examine the CCC Program from such perspectives. Collectively, these case studies (along with information obtained from a survey of almost 700 program participants) suggest that CCC care coordination activities improved individuals' quality of care, quality of life, and satisfaction.

Eugene, a CCC beneficiary (center) with Elizabeth, his Humana/Beacon Health Options' behavioral health care manager (right) and Albert, his mental health skill building counselor (left).

Eugene's Story

Eugene is 57 years old and has a serious mental illness (SMI) along with several other chronic health conditions.[1,2] He also receives full Medicare and Medicaid benefits, lives at home with a family member, and has a history of hospitalizations. Known as dual eligible beneficiaries, individuals like Eugene often account for high healthcare costs because they have complex needs that are not adequately addressed through the fee-for service system (FFS).[3,4,5]

In an effort to reduce costs while improving care for dual eligible beneficiaries, Virginia implemented a new managed care initiative known as the Commonwealth Coordinated Care (CCC) Program in the spring of 2014. Soon afterwards, Eugene enrolled with Humana, one of the three participating Medicare-Medicaid Plans (MMPs).[6,7] Once enrolled, individuals have access to standard Medicare and Medicaid benefits as well as extra benefits not typically covered under these programs, such as gym membership, over-the-counter (OTC) pharmacy, health education, dental cleanings, and eye exams. (The extra benefits offered vary by MMP. The gym membership, OTC pharmacy, and health education benefits are specific to Humana.) Eugene has used some of these benefits since enrolling in the program. For example, he used Humana's gym membership benefit to join a local YMCA based on advice from his cardiologist. Eugene said, "My doctor recommended that I cycle, so I've been doing that consistently twice a week...I've gone about 60 times so far." When asked about the pharmacy benefit, Eugene said, "I've used it to buy ibuprofen, pill boxes, and a digital blood pressure monitor." Eugene also used the health education benefit to take a heart disease class at a local hospital. Reflecting on this, he said "…I learned about congestive heart failure and [the importance of] weighing myself to head off any kind of emergency…"

While these benefits are helpful, the main benefit individuals receive after enrolling is care coordination, a person-centered process designed to assist them with gaining access to needed health and social support services. This benefit is provided by an MMP care coordinator (usually a nurse or social worker) in collaboration with the individual, family, and providers. Because Eugene has several chronic conditions, he has two coordinators. The first is Sarah Jane, a registered nurse who works for Humana and coordinates his

medical care. The second is Elizabeth, a clinical social worker who works for Beacon Health Options (Humana's BH partner) and coordinates his behavioral health services.[8] Other key members of Eugene's support network include Albert, a mental health skill building counselor, and Antoine, his brother and power of attorney.[9]

Due to the fragmented nature of the FFS system, many beneficiaries receive care from multiple providers who are usually unaware of their colleagues' treatments. This lack of coordination often results in conflicting advice, contraindication in care regimens, and medical errors. Before Eugene enrolled with Humana, he was receiving care from several providers, including two primary care physicians (PCPs), so Sarah Jane and Elizabeth worked to eliminate some of them. Recalling this, Sarah Jane said, "…our first challenge was to streamline things…Eugene had nine different providers…we got him down to seven including one PCP…we've been trying to streamline as much as possible so we don't have duplication of services…" Because Eugene was not receiving care for his SMI, Sarah Jane and Elizabeth also helped him access psychiatry, mental health skill building, and day support services as part of this process.

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– Elizabeth
(Beacon Health Options Care Manager)

For care coordination to be effective, all parties must be engaged and actively exchanging information. Good communication is critical, especially when it concerns medications. Elizabeth said, "Eugene was taking 20 prescriptions, but we got them down to 15…the issue was his doctors weren't talking…we got releases signed so now his psychiatrist knows what his PCP is prescribing so they're not prescribing double…they're now talking and are on the same page as far as medications go and aren't prescribing ones that counteract each other…" Sara Jane echoed this, "We've been calling all his providers, getting them to send their lists of medications to his PCP who acts as a central hub for his health care…a lot of [our communication has] been emails just updating each other when something happens, we communicate and make sure everybody is on the same page." Albert agreed, "…we definitely work well together, if there are issues I need help with, I know I'll get it…so it's a great team…", while Antoine said, "[we] talk often…the communication is flawless…Sarah Jane has a lot of close contact with us…"

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– Sarah Jane
(Humana Care Coordinator)

Because proper medication therapy is important for improving health outcomes for individuals with multiple chronic conditions, Eugene's support network next focused on medication compliance and reconciliation. Sarah Jane said, "…Eugene was going to the hospital emergency department (ED) a lot…so preventing hospitalizations was a big focus…we really couldn't determine what his true health needs were until he was compliant with his medications, so we focused on medication reconciliation and [education]…" As part of this, Sarah Jane contacted Eugene's PCP for a referral so a home health nurse could help with medication reconciliation. This proved invaluable for reducing his hospitalizations. Albert said, "…the nurse goes to his home once a week and sets up his pill boxes and makes sure he is taking the right medications…he has quit an extensive medication list…she sets [them] up so he knows which prescriptions to take in the morning, afternoon, and

evening…[health] issues can be eliminated with medication compliance…so this has really helped a lot..." Elizabeth agreed, "…the home health nurse was a huge benefit…Eugene was going to the ED just about every month during 2015, but he's only gone to the ED six times in 2016 and hasn't been back since August…"

When asked about Eugene's progress since enrolling in the CCC Program, Antoine said, "…Eugene's easier to get along with…he's calmer…I've seen progress…it's been good…" Elizabeth concurred, "I've noticed changes in his behavior…he's not as agitated…I see Eugene growing leaps and bounds…he's a lot more calm and communicates better since we started so I think it's a huge difference…", while Albert said, "Eugene's been receptive…he's more agreeable…he's showing a lot of behavior [improvement]…" Eugene simply said, "…it's working, there are good signs…they are making me more knowledgeable…I can call Sarah Jane and she knows who I am, so it helps…we talk a lot, so it's good…it's good…"

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– Elizabeth
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Endnotes

[1]Informed consent was obtained from all participants prior to data collection. The information in this case study was collected during an interdisciplinary care team meeting at the beneficiary's home.
[2]Examples of serious mental illness (SMI) include anxiety, bipolar disorder, depression, and schizophrenia, while examples of chronic illness include arthritis, chronic obstructive pulmonary disease, congestive heart failure, and diabetes.
[3]Burns, M.E., Huskam, H.A., Smith, J.C., Madden, J.M., & Soumerai, S.B. (2016). The effects of the transition from Medicaid to Medicare on health care use for adults with mental illness. *Medical Care*, 54(9): 868-877.
[4]Frank, R.G & Epstein, A.M. (2014). Factors associated with high levels of spending for younger dually eligible beneficiaries with mental disorders. *Health Affairs*, 33(4): 1006-1013.
[5]Schraeder, C. & Shelton, P. (Eds.) (2011). *Comprehensive Care Coordination for Chronically Ill Adults*. West Sussex, UK: John Wiley & Sons, Inc.
[6]The three participating MMPs are Anthem Healthkeepers, Humana, and Virginia Premier.
[7]Individuals in the CCC Program are considered either "long term service and support" (LTSS) or "community well" (CW) depending on whether they require nursing facility level of care. LTSS individuals require nursing facility level of care and either reside in nursing facilities or are enrolled in the Elderly or Disabled with Community Direction (EDCD) home and community-based waiver. CW individuals do not require nursing facility level of care and reside in community settings.
[8]Because coordinating care for individuals with SMI requires specialized knowledge, Humana contracted with Beacon Health Options (an international BH management company) to provide care coordination assistance to this population.
[9]Sarah Jane provides Eugene with telephonic care coordination assistance because he is CW. However, Elizabeth provides in-person coordination because Eugene has an SMI and is considered "vulnerable" under the CCC Program.

CCC EVALUATION OVERVIEW

Because the CCC Program represented a new care delivery model in Virginia, the Department of Medical Assistance Services (DMAS) partnered with George Mason University (Mason) to evaluate it using a team composed of agency staff and university faculty. DMAS staff were responsible for the qualitative component of the evaluation, while Mason faculty were responsible for the quantitative component. The evaluation lasted more than two years and ended on September 30, 2016. For additional information on the evaluation, please contact Gerald Craver at gerald.craver@dmas.virginia.gov or see http://www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx.